

2025 Enrollment Request Form

☐ UHC Dual Complete WA-S2 (PPO D-SNP) H2001-081-000

Information about you (Please	type or pri	nt in black or	blue ink)	
Last name	First name			Middle initial	
Birth date		Sex □ Male	☐ Female		
Home phone number ()	_	Mobile phone	() –		
☐ I give consent for UnitedHealthcare and its affiliates to call the phone number(s) I have provided using an autodialer and/or prerecorded voice technology.					
Social Security number (Required for people who are enrolling in D-SNP plans):					
Medicare number					
Permanent residence street address (Don't enter a P.O. box. Note: For individuals experiencing homelessness, a PO Box may be considered your permanent residence address)					
City	County State		Zip code		
Mailing address (Only if it's different from above. You can give a P.O. box.)					
City	State		Zip code		
Email address (optional)					
Enrollee name					
Agent name/ID number				W.W.A.O.F.I. PO.O.G. 4.O.F.T	
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Do you have other insurance (Examples: Other private insura programs.) If yes, what is it?		•	☐ Yes ☐ No benefits or state	
Name of other insurance				
Member number	Group number	RxBin	RxPCN (optional)	
Answering these questions is fill them out.	your choice. You can't be de	enied coverage b	ecause you don't	
How do you want to pay? If you have a monthly plan prer pay your premium by automatic Board (RRB) benefit check each Electronic Funds Transfer (EFT)	nium (including any late enroll c deduction from your Social S ch month. You can also pay fro	Security or Railroa	d Retirement	
If you don't choose an option b	elow, we'll send a bill each mo	onth to your mailir	ng address.	
If you must pay a Part D-Incom	e Related Monthly Adjustment	Amount (Part D-I	RMAA),	
Social Security (SS) will send y	ou a letter and ask you how yo	u want to pay it:		
☐ You can pay it from your SS check				
☐ Medicare can bill you				
☐ The Railroad Retirement Board (RRB) can bill you				
☐ I want to pay from my Social	Security check			
☐ I want to pay from my Railro	ad Retirement Board (RRB) ch	neck		
☐ I want to pay directly from a bank account				
Account type ☐ Checking I	☐ Savings			
Account holder name:				
Bank routing number/////				
Bank account number/_				
A few questions to help u	s manage your plan			
1. Would you prefer plan info	rmation in another language	or an accessible	format?	
	mation in another language or Braille □ Large print □ Audi			
Enrollee name				
Agent name/ID number Y0066_ERFMA_2025_C			 /A25LP0221057_000	

If you don't see the language or format you want, please call us toll-free at **1-844-560-4944**, TTY **711**, 8 a.m.-8 p.m. local time, 7 days a week. Or visit **UHC.com/CommunityPlan** for online help.

2. Are you enrolled in Washington Apple I If yes, please give us your ProviderOne S	□ Yes □ No	
3. Are you Hispanic, Latino/a, or Spanish No, not of Hispanic, Latino/a, or Spanish Yes, Mexican, Mexican American, o Yes, Puerto Rican Yes, Cuban Yes, another Hispanic, Latino, or Spanish	anish origin r Chicano/a	
4. What's your race? Select all that apply.		
American Indian or Alaska Native	Black or African American	
Asian: Asian Indian Chinese Filipino Japanese Korean	Native Hawaiian or Pacific Islander: Guamanian or Chamorro Native Hawaiian Samoan Other Pacific Islander	
Vietnamese Other Asian	White I choose not to answer	
Member/Citizen of a federal or state	recognized Tribe (name of Tribe)	
5. What is your gender? Select one. Woman Man Non-binary	I use a different term: I choose not to answer	
6. Which of the following best represents Lesbian or gay Straight, that is, not gay or lesbian Bisexual	I use a different term:	
7. Do you or your spouse work?		□ Yes □ No
Enrollee name		
Agent name/ID number		

Do you or your spouse have other health insurance	
(Examples: Other employer group coverage, LTD	
auto liability, or Veterans benefits)	☐ Yes ☐ No
If yes, please complete the following:	
Name of health insurance company	
Member number	
8. Please give us the name of your primary care	e provider (PCP), clinic or health center.
You aren't limited to this list. You may go to any d	octor who accepts Medicare and the plan's
payment terms.	
You can find a list on the plan website or in the Pr	rovider Directory.
Provider or PCP full name	
Provider/PCP number	(Please enter the number exactly as it appears on
	the website or in the Provider Directory. It will be
	10 to 12 digits. Don't include dashes.)
Are you now seeing or have you recently seen thi	s provider? ☐ Yes ☐ No
	ally enrolls you in paperless delivery for some of
your plan communications.	
You will get many of your required plan communi	•
•	e: Explanation of Benefits or the Annual Notice of
changes) are available online. You can access the computer, tablet or mobile phone.	ese communications through any device such as a
•	
If you would rather have hard copies of require	d materials mailed to you, please check here:
☐ Instead of paperless delivery, we will mail you h	nard copies of required materials. Please note that
some communications are very large and may	not fit in all mailboxes. You can change your
preference for delivery at any time.	
Please read and sign	
By completing this form, I agree to the following	g:
□ I must keep both Hospital (Part A) and Medic	cal (Part B) to stay in UnitedHealthcare. I must keep
paying my Part B premium if I have one, unle	ess Medicaid or someone else pays for it.
·	generally not covered under Medicare while out of
	r the U.S. border. This plan covers emergency and
urgent care outside of the U.S. See the Sum	•
•	coverage begins, I must get all of my medical and
prescription drug benefits from UnitedHealth	care. Benetits and services authorized by
Enrollee name	
Agent name/ID number	
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•	nown as a member contract or subsc	,				
	nor UnitedHealthcare will pay for benefits or services that are not covered. I understand that I can be enrolled in only one Medicare Advantage (MA) plan at a time – and					
	that enrollment in this plan will automatically end my enrollment in another MA plan (exceptions					
	apply for MA Private Fee-for-Service (PFFS), MA Medicare Medical Savings Account (MSA)					
	plans). Release of information: By joining this Medicare Advantage Plan, I acknowledge that the plan					
	will share my information with Medicare, who may use it to track my enrollment, to make					
	payments, and for other purposes allowed by Federal law that authorize the collection of this					
	information (see Privacy Act Statement below).					
•	9					
or pers plan.	or person(s) for permissible purposes under applicable law as required to administer my health					
•	formation on this form is correct to the	e best of my knowledge. I u	understand that if I			
intenti	intentionally provide false information on this form I will be disenrolled from the plan.					
-	sponse to this form is voluntary. Howe	ver, failure to respond may	affect enrollment in the			
plan.						
When I sig	n below, it means that I have read a	nd understand the inform	ation on this form			
_	an authorized representative, it means					
•	en proof (power of attorney, guardians		•			
understand	d that I will need to submit written prod	of of this right, to the plan, i	f I wish to take action on			
	ne member beyond this application. A	• •	• •			
	ny UnitedHealthcare UCard®, I can cal Ithcare UCard to update my authoriza		umber on my			
			3- J-L-			
Signature	of applicant/member/authorized re	presentative Loday	<i>ı</i> 's date			
If you are	e the authorized representative	, please sign above ar	nd complete the			
_	ion below (*Not a Sales Agent)		•			
Last name	, , , , , , , , , , , , , , , , , , ,	First name				
Address						
City		State	Zip code			
Phone nun	nber () —	Relationship to applicar	nt			
Enrollee nar	me					
	e/ID number					

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UnitedHealthcare and contained in my UnitedHealthcare "Evidence of Coverage" document

Fautadividuala bal				in a this fames a	and a c	
For individuals hell Complete this section			-	_	-	
members, or other thir	•		•		ouriseiors, rairilly	
Name	7 1 3			hip to enrollee		
					<u> </u>	
Signature		Natio	National Producer Number (Agents/Brokers only)			
For Licensed Sales	s Representative/	agend	cy u	se only		
Licensed Sales repres	entative/Writing ID			Initial receipt date	е	
Licensed Sales repres	entative/agent name			Proposed effective date		
Employer group name						
Employer group ID			В	ranch ID		
Agent must complete)					
☐ IEP (MA-PD	☐ ICEP (MA enrolle	,		P (MA-PD	□ OEP (Jan 1 -	
enrollees)				lees eligible for	Mar 31)	
☐ OEP (Newly	☐ SEP (Dual LIS		2nd I ⊐ SE	EP (Change in	☐ SEP (Loss of	
eligible)	change of status)			ence)	EGHP coverage)	
☐ SEP (Chronic)	☐ SEP (Dual LIS	,		P (October 15-	□ OEPI	
	maintaining)	Decen		mber 7)		
☐ SEP (SEP reason) _						
Enrollee name						
Agent name/ID number					_	
Y0066_ERFMA_2025_C					UHWA25LP0221057_000	

Licensed Sales representative signature (optional)

Date

Please mail or fax this completed form to:

UnitedHealthcare P.O. Box 30770 Salt Lake City, UT 84130-0770

Fax: 1-888-950-1170
Fax the front and back of each page

PRIVACY ACT STATEMENT: The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) or Prescription Drug Plans (PDP), improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50, 422.60, 423.30 and 423.32 authorize the collection of this information. CMS may use, disclose and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (MARx)", System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

UHC Dual Complete WA-S2 (PPO D-SNP) is insured through UnitedHealthcare Insurance Company or one of its affiliated companies, a Medicare Advantage organization with a Medicare contract and a contract with the State Medicaid Program. Enrollment in the plan depends on the plan's contract renewal with Medicare.

This information is available for free in other languages. Please call our customer service number located on the back cover of this book.

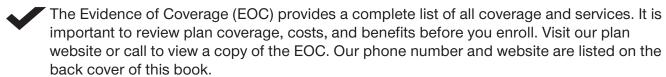
Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

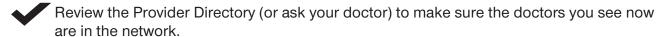
OMB No. 0938-1378 Expires: 6/30/2026 Y0066_ERFMA_2025_C

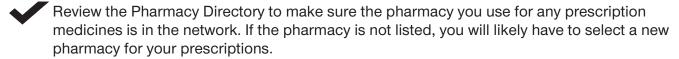
Enrollment checklist

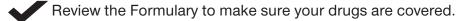
Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a Customer Service Representative at the number listed on the back cover of this book.

Understanding the benefits

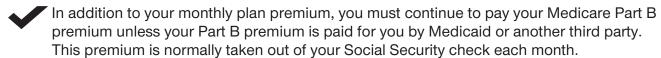




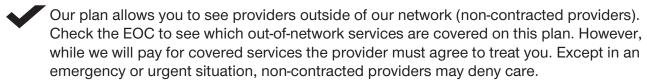




Understanding important rules







Effect on Current Coverage. If you are currently enrolled in a Medicare Advantage plan, your current Medicare Advantage health care coverage will end once your new Medicare Advantage coverage starts. If you have TRICARE, your coverage may be affected once your new Medicare Advantage coverage starts. Please contact TRICARE for more information. If you have a Medigap plan, once your Medicare Advantage coverage starts, you may want to drop your Medigap policy because you will be paying for coverage you cannot use.

This plan is a Dual Eligible Special Needs Plan (D-SNP). Your ability to enroll will be based on verification that you are entitled to both Medicare and medical assistance from a state plan under Medicaid.